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**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

By signing this form, I authorize RETINA AND VITREOUS OF TEXAS, P.L.L.C. to release all medical information including test results and future appointment dates and/or times to the following friends or relatives. If I do not designate anyone I understand that the doctor or clinical staff will be unable to speak with anyone regarding my medical condition.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

I understand that the information in my health record may include information relating to sexually transmitted diseases, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that I have the right to request this information not be disclosed.

YES, I consent to release this information  NO, I do not consent to release this information

I understand that RETINA AND VITREOUS OF TEXAS, P.L.L.C. may need to contact me with information related to my care and that I may not always be available when contact is attempted. I authorize RETINA AND VITREOUS OF TEXAS, P.L.L.C. to contact me and leave a message for me at the following:

At my home  At my place of employment  Other: \_\_\_\_\_

I understand that RETINA AND VITREOUS OF TEXAS, P.L.L.C. may from time to time send me marketing information about the practice. I understand that I have the right to consent to receiving this information. I understand that by giving my consent I am authorizing RETINA AND VITREOUS OF TEXAS, P.L.L.C. to send me marketing information about the practice that has no financial remuneration to RETINA AND VITREOUS OF TEXAS, P.L.L.C. and that any marketing information that does have financial remuneration to RETINA AND VITREOUS OF TEXAS, P.L.L.C. requires a separate authorization, from me, in writing.

I consent to receive marketing information  I do not consent to receive marketing information

\_\_\_\_\_  
Patient/Guardian Signature | \_\_\_\_\_  
Date

\_\_\_\_\_  
Patient/Guardian Printed Name